APPLICATION FOR COMPENSATION

RETURN APPLICATION TO:

CRIME VICTIMS COMPENSATION PROGRAM
INDUSTRIAL COMMISSION
P.O. BOX 83720
BOISE ID 83720-0041
(208) 334-6080 or (800) 950-2110

PLEASE NOTE: YOU MUST COMPLETE ALL OF THE FOLLOWING INFORMATION ON EACH OF THE FOUR PAGES OF THIS APPLICATION. PLEASE PRINT CLEARLY.

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1. INFORMATION REQUIRED ABOUT THE VICTIM SEX: MALE_____ FEMALE_____

VICTIM'S NAME: _____ MARITAL STATUS:_____

VICTIM'S MAILING ADDRESS: _____

CITY/STATE: _____ ZIP: _____ PHONE :(_____)_____

VICTIM'S SOCIAL SECURITY NUMBER:_____ VICTIM'S BIRTH DATE: ___/_____/_____

VICTIM'S DATE OF DEATH: ____/____/_____ (if applicable)

DID THE VICTIM MISS AT LEAST A WEEK OF WORK AS A RESULT OF CRIME RELATED INJURIES?

No____ Yes_____IF YES, please complete the following:

VICTIM'S EMPLOYER'S BUSINESS NAME AT THE **TIME OF CRIME**:_____

VICTIM'S EMPLOYER'S MAILING ADDRESS :_____

CITY/STATE:_____ ZIP:_____ PHONE: (_____)_____

CONTACT PERSON_____ PAY RATE $_____ PER HOUR

DATES MISSED WORK: FROM_____ TO _____

DID THE VICTIM RECEIVE TIPS OR GRATUITIES? No_____ Yes _____ If yes, please estimate the amount per week the victim received _____

2. IF THE VICTIM IS DECEASED, PROVIDE THE FOLLOWING INFORMATION (If the victim is not deceased, SKIP THIS SECTION AND GO TO SECTION NO. 3)

DID THE VICTIM HAVE CHILDREN OR OTHER DEPENDENTS? _____ IF SO PLEASE COMPLETE THE FOLLOWING:

Name of Child/Dependent	Date of Birth	Relationship to Victim

If additional space is needed, please attach separate sheet of paper

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*****CONTINUE TO PAGE 2 OF THE APPLICATION *****

3. IF YOU ARE SIGNING THIS APPLICATION FOR A MINOR, INCAPACITATED OR DECEASED VICTIM, THE FOLLOWING INFORMATION IS REQUIRED ABOUT YOU

YOUR NAME:_____

YOUR EMPLOYER'S NAME:_____ PHONE (_____)_____

YOUR SOCIAL SECURITY NUMBER: _____ PHONE (_____)_____

YOUR MAILING ADDRESS: _____

CITY/STATE:_____ ZIP: _____

YOUR RELATIONSHIP TO VICTIM: _____
(IF LEGAL GUARDIAN and /or CONSERVATOR – YOU MUST PROVIDE COPY OF COURT ORDER)

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4. INFORMATION REQUIRED ABOUT THE CRIME

TYPE OF CRIME: _____
DATE OF CRIME :_____TIME_____AM/PM (or From _____ To _____)
LOCATION OF CRIME: (Town/City)_____ (Street address where crime occurred)_____

LAW ENFORCEMENT AGENCY CRIME REPORTED TO:_____
DATE CRIME DISCOVERED:_____ DATE CRIME REPORTED :_____TIME _____AM/PM

NAME OF INVESTIGATING OFFICER_____ REPORT NO :_____

NAME OF PERSON(S) WHO COMMITTED CRIME :_____

RELATIONSHIP TO VICTIM AND AGE OF PERSON(S) WHO COMMITTED CRIME :_____
(example: friend, acquaintance, uncle, brother, sister, stranger, etc.)

BRIEFLY DESCRIBE INCIDENT (If additional space is needed, please attach separate sheet of paper)

_____

_____

_____

NAME OF VICTIM/WITNESS COORDINATOR:_____

HOW DID YOU LEARN OF THIS PROGRAM?_____

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5. STATISTICAL INFORMATION: The following information is used for statistical purposes only. It is needed to comply with federal regulations.

Race: White _____ Black _____ Native American _____ Hispanic _____ Oriental/Asian _____ Other _____
Are you a U. S. citizen? Yes _____ No _____
Are you an Idaho resident? Yes____ No_____
Disabilities: Hearing _____ Mobility _____ Visual _____ Mental _____ Multiple _____ Other _____ None _____

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*****CONTINUE TO PAGE 3 OF THE APPLICATION*****

6. INFORMATION REQUIRED ABOUT INSURANCE AND OTHER BENEFIT SOURCES

CHECK IF THE VICTIM IS COVERED BY ANY OF THE FOLLOWING BENEFITS:

□ CAR INSURANCE □ MEDICAL INSURANCE □ HEALTH & ACCIDENT INSURANCE
□ WORKERS COMPENSATION □ DISABILITY INSURANCE □ SOCIAL SECURITY BENEFITS
□ INDIAN HEALTH SERVICES
□ MEDICARE : MEDICARE NO. _____ □ MEDICAID : MEDICAID NO._____
Effective Date:_____ Effective Date:_____
□ OTHER: (explain)_____

NAME & ADDRESS OF INSURANCE COMPANY:_____

POLICY NO. AND/OR
_____ TELEPHONE NO: _____ CLAIM NO. _____
PLEASE CHECK WHICH TYPE OF COVERAGE YOUR POLICY IS: ˆ Medical ˆ Auto ˆ Life Insurance ˆ Home Owners

SECOND INSURANCE POLICY INFORMATION:
NAME & ADDRESS OF INSURANCE COMPANY _____

POLICY NO. AND/OR
_____ TELEPHONE NO:_____ CLAIM NO. _____
PLEASE CHECK WHICH TYPE OF COVERAGE YOUR POLICY IS: ˆ Medical ˆ Auto ˆ Life Insurance ˆ Home Owners

ARE YOU BEING REPRESENTED BY A PRIVATE ATTORNEY IN A CIVIL LAWSUIT OR INSURANCE ACTION RELATING TO THIS INCIDENT ?_____

ATTORNEY'S NAME _____ PHONE NO (_____)_____

ATTORNEY'S ADDRESS_____

CITY/STATE_____ ZIP _____

IF YOU HAVE NOT SUED THE PERSON WHO COMMITTED THE CRIME IN A CIVIL ACTION, DO YOU PLAN TO SUE THAT PERSON? YES _____ NO _____

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7. INFORMATION REQUIRED REGARDING MEDICAL, DENTAL, MENTAL HEALTH TREATMENT, ETC.

LIST NAMES OF ALL DOCTORS, DENTISTS, CLINICS, HOSPITAL, COUNSELORS, AMBULANCE, AND ANY OTHERS WHO HAVE PROVIDED TREATMENT OR SERVICES TO THE VICTIM RELATING TO THE CRIME. (Attach additional pages if necessary).

COMPLETE NAME OF PROVIDER **COMPLETE MAILING ADDRESS, CITY, STATE ZIP**

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******CONTINUE TO PAGE 4 OF THIS APPLICATION******

EACH OF THE FOLLOWING SECTIONS MUST BE AGREED TO AND SIGNED TO RECEIVE COMPENSATION

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8. INFORMATION RELEASE

I give permission to release to and receive from any hospital, clinic, doctor, insurance company, employer, mental health provider, treatment center, person, agency or any other entity any needed information to the IDAHO CRIME VICTIMS COMPENSATION PROGRAM, for _____ (name of victim). I also give permission to the Program to release copies of any of my medical or mental health records necessary to the prosecuting attorney to secure restitution from the alleged offender in order to reimburse the fund.

I understand the information will be used to determine compensation benefits, and that only information needed to make a decision about the application or any claim for compensation benefits or otherwise deemed necessary by the Program to achieve its statutory mandate will be requested from other entities or released by the Program. With these exceptions, all information provided will be kept strictly confidential.

I understand this information release is valid until my claim is closed, as provided in Idaho Code § 72-1014, and that I can cancel this release by writing to the Program at any time, but that such cancellation will result in my claim not being processed further.

I understand a photocopy or facsimile of this signed form is as valid as the original, and that my signature gives permission for the release of all information specified in this permission form.

Federal law specifically requires that any disclosure or redisclosure of mental health, drug/alcohol or AIDS related information must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CRF Part 2). The Federal rules prohibit you from making any further disclosure of this information unless disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any drug/alcohol abuse patient.

XXX_____ DATE _____
Applicant signature (parent or guardian must sign if victim is a minor)
Printed Name of Applicant _____relationship to victim _____

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9. REPAYMENT AND SUBROGATION AGREEMENT

I understand that Idaho law requires me to contact and repay the Program if I have already received or receive in the future any payments from the offender, a civil lawsuit, an insurance program, any other government or private agency or any other source resulting from the criminal offense upon which this application was made. I also acknowledge that the Program has a first lien against any money payable to me from any of such sources.

I understand and agree to the terms of this Repayment And Subrogation Agreement.

XXX_____ DATE _____
Applicant signature (parent or guardian must sign if victim is a minor)
Printed Name of Applicant _____relationship to victim_____

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10. APPLICATION CERTIFICATION

I certify that the information in this application is true and correct to the best of my knowledge. I understand that I must use all financial resources available to me including but not limited to, medical/health insurance, workers compensation, disability insurance, VA benefits, Medicaid/Medicare, Social Security, auto insurance and sick leave prior to the Program paying any benefits. I understand by signing below I agree to all of the provisions in this Application for Compensation. If the victim is deceased, I certify that I have authority to file this application on behalf of all surviving dependents, including minor children, entitled to apply for benefits under the Program, unless a separate application has been filed for that dependent.

XXX_____ DATE _____
Applicant signature (parent or guardian must sign if victim is a minor)
Printed Name of Applicant _____relationship to victim_____

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